Federally Qualified Health Center Payment Process Quick Reference Guide

Wrap Payment Process and Methodology
Superior HealthPlan will initiate claims system changes for Federally Qualified Health Center (FQHC) claims with dates of service of September 1, 2017 and later. The changes will align with the Texas Health and Human Services (HHS) contract amendment and direction related to FQHC payments, which include required claims elements for reimbursement of FQHC claims at Fee-For-Service + Wrap Service = Prospective Payment System (PPS) Encounter Rate, and encounter submission to HHS for Superior reimbursement of wrap service payment amounts.

To maintain consistent claims processes for FQHCs, Superior will require both Medicaid and CHIP claims to be billed using the requirements listed below.

General Claims Requirements
Provider must bill claims:

- On a CMS1500 claim form.
- With the rendering/servicing provider NPI/taxonomy in box 24 I/J, if required.
- With the billing provider’s NPI in box 33a and billing provider’s taxonomy in box 33b.
- With the location where services were provided in box 32.
  - With the NPI of the facility where the services were provided in box 32a.
  - With the taxonomy of the facility where the services were provided in box 32b (Please note: boxes 32a and 32b can differ from NPI and taxonomy in 33a and 33b).
- With the appropriate location code where the services were provided, for services provided outside the FQHC site (i.e. location 21 for inpatient hospital). Please note: Services performed outside FQHC will be paid at the Medicaid Fee-For-Service reimbursement rate.

Claims Requirements to Trigger PPS Rate (Medicaid Fee-For-Service + Wrap Service)
Provider must bill claims:

- On a CMS1500 claim form.
- Using Location Code 50.
- With the billing provider’s NPI in box 33a and billing provider’s taxonomy (261QF0400X) in box 33b.
  - 33b must be a FQHC taxonomy code to trigger PPS encounter rate payment and for Superior encounter submission.
- With a procedure code T1015 and all applicable modifiers (AH, AJ, AM, SA, TD, TE, or U7) in order to receive an encounter payment, and a PPS rate on first service line of the claim form, in addition to appropriate procedure codes for services provided (including all applicable modifiers and the provider’s usual customary charge). Please note: Providers will not be reimbursed an encounter rate without a face-to-face encounter procedure code billed in addition to the T1015 procedure code.
- With a modifier TH for antepartum or postpartum care.
- With the appropriate family planning diagnosis code for family planning services.
- Rendering Provider NPI/taxonomy required for THSteps and Family Planning visits.
- For each face-to-face encounter, along with the procedure code for services provided on a separate claim (example: THStep visit, BH visit and General Medical visit would be billed on separate claims).

Claims Payment

- Superior will adjudicate procedure codes submitted at Medicaid Fee-For-Service. Simultaneous wrap service (up to PPS encounter rate) will be calculated and paid for the T1015 procedure code and include reimbursement at the full FQHC PPS encounter rate.
- The total claim payment will not exceed the provider’s PPS encounter rate, unless codes for after-hours services or Long-Acting Reversible Contraception (LARC) procedure codes (J7297, J7298, J7300, J7301, and J7307) are billed. Please note: After-hours care and LARC services will be paid in addition to the provider’s PPS encounters rate.
- FQHCs with questions about denied claims or concerns about payment accuracy should call Superior’s Provider Services department at 1-877-391-5921. Provider Services will be able to explain the reason for the claim denial or payment amount and determine appropriate next steps.
<table>
<thead>
<tr>
<th>Date</th>
<th>Code</th>
<th>Procedure</th>
<th>Modifier</th>
<th>Diagnoses</th>
<th>Charges</th>
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<tbody>
<tr>
<td>02 08 2018</td>
<td>T1015</td>
<td>FP AM AB</td>
<td>151</td>
<td>03</td>
<td>1</td>
</tr>
<tr>
<td>02 08 2018</td>
<td>99214</td>
<td>FP AM AB</td>
<td>200</td>
<td>00</td>
<td>1</td>
</tr>
</tbody>
</table>
**HEALTH INSURANCE CLAIM FORM**

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12**

### Field 1: **DATE OF SERVICE**
- **Name:** Random TX Health Center
- **Address:** 100 Main St.
- **City:** Random, TX. 77777
- **PHONE (Include Area Code):** (111) 111-1111

### Field 11: **DIAGNOSIS CODE**
- **Code:** Z30430

### Field 12: **PROCEDURE CODE**
- **Code:** T1015

### Field 13: **AMOUNT CHARGED**
- **Amount:** 150

### Field 14: **AMOUNT PAID**
- **Amount:** 0

### Field 15: **AMOUNT DUE**
- **Amount:** 1

### Field 16: **CPT/HCPCS CODE**
- **Code:** 58300

### Field 17: **NAME OF RECOGNIZING PROVIDER OR OTHER SOURCE**
- **Name:** T2a
- **Qual.:** 170

### Field 18: **HOSPITALIZATION DATES RELATED TO CURRENT SERVICES**
- **From:** 01/02/2018
- **To:** 02/02/2018

### Field 23: **CPT/HCPCS CODE**
- **Code:** J7301
- **Qual.:** U8

### Field 24: **CPT/HCPCS CODE**
- **Code:** 99213

### Field 25: **CPT/HCPCS CODE**
- **Code:** 58300

### Field 26: **CPT/HCPCS CODE**
- **Code:** 123456789

### Field 27: **CPT/HCPCS CODE**
- **Code:** 261QF0400X

### Field 28: **CPT/HCPCS CODE**
- **Code:** 261QF0400X

### Field 29: **CPT/HCPCS CODE**
- **Code:** 261QF0400X

### Field 30: **CPT/HCPCS CODE**
- **Code:** 261QF0400X

**Please Print or Type**

**Sample Form**

**Approved OMB-0938-1197 FORM 1500 (02-12)**
Superior - Sick Visit  
(T1015 with F2F)

HEALTH INSURANCE CLAIM FORM  
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PIGA

1. MEDICARE | MEDICAID | TRICARE | CHAMPVA | GROUP HEALTH PLAN | FECA | OTHER
(Medicaid) | (Medicaid) | (Medicare-Medicare) | Group Health Plan | FECA | Other

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE (MM DD YY)

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT'S RELATIONSHIP TO INSURED
   Spouse | Parent | Child | Other

7. INSURED'S ADDRESS (No., Street)

8. RESERVED FOR NUCC USE

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:
   a. EMPLOYMENT? (Current or Previous) YES | NO
   b. AUTO ACCIDENT? YES | NO
   c. OTHER ACCIDENT? YES | NO

11. INSURED'S POLICY GROUP OR FECA NUMBER

12. IS THERE ANOTHER HEALTH BENEFIT PLAN?
   YES | NO

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)
   MM DD YY

15. OTHER DATE QUAL
   MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
   FROM MM DD YY TO MM DD YY

17. NAME OF REFERING PROVIDER OR OTHER SOURCE
   TZA

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
   FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES | NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY:  
   (Refer to service line below (3ME) ICD Ind)
   A D L C G H I J

22. REIMBURSEMENT CODE

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE
   FROM MM DD YY TO MM DD YY
   B. PLACE OF SERVICE
   C. PROCEDURES, SERVICES, OR SUPPLIES
   (Explain Unusual Circumstances)
   D. CODE OR UNITS
   E. DIAGNOSIS CODE
   F. CHARGES
   G. AMOUNT OR UNITS
   H. DUR. OR UNITS
   I. NPI
   J. RENDERING PROVIDER ID, #

   01 12 2018 01 12 2018 T1015 AM A 156 03 1 NPI

   01 12 2018 01 12 2018 50 99213 AM A 150 00 1 NPI

25. MEDICAL TAX ID NUMBER

26. PATIENT'S ACCOUNT NO

27. ACCEPT ASSIGNMENT? YES | NO

28. TOTAL CHARGE

29. AMOUNT PAID

30. Rev. for NUCC Use

SIGNED

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)
**HEALTH INSURANCE CLAIM FORM**

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12**

<table>
<thead>
<tr>
<th>1. MEDICARE</th>
<th>2. PATIENT'S NAME (Last Name, First Name, Middle Initial)</th>
<th>3. PATIENT'S BIRTH DATE DD MM YYYY</th>
<th>4. INSURED'S NAME (Last Name, First Name, Middle Initial)</th>
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<thead>
<tr>
<th>5. PATIENT'S ADDRESS (No., Street)</th>
<th>6. PATIENT RELATIONSHIP TO INSURED</th>
<th>7. INSURED'S ADDRESS (No., Street)</th>
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<thead>
<tr>
<th>CITY</th>
<th>STATE</th>
<th>ZIP CODE</th>
<th>TELEPHONE (Include Area Code)</th>
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<tr>
<th>9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</th>
<th>10. IS PATIENT'S CONDITION RELATED TO:</th>
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**READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.**

**SIGNED**

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<th>12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE</th>
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**SUPERIOR- THSTEPS with vaccines**

(T1015 with F2F, immunization, and admin)

**Address**

Random TX Health Center
100 Main St.
Random, TX. 77777